Southern District Health Board
(now Te Whatu Ora Southern)

A Report by the
Deputy Health and Disability Commissioner

(Case 21HDC00522)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a man at Southland Hospital, in particular the unacceptable delays he experienced in the management of referrals for the treatment of his perianal abscesses from September 2020 to February 2021. It highlights the importance of having adequate systems in place for the management of referrals, and good communication with consumers.

Findings

2. The Deputy Commissioner considered that Te Whatu Ora Southern did not provide services with reasonable care and skill, as the multiple delays the man experienced in receiving the consultations and treatment he required were unacceptable. Te Whatu Ora Southern was found in breach of Right 4(1) of the Code. The Deputy Commissioner was also critical of the poor communication and lack of courtesy shown to the man at points in his care, which contributed further to his poor experience at Southland Hospital.

Recommendations

3. The Deputy Commissioner recommended that Te Whatu Ora Southern provide a written apology for the failures of care identified; use an anonymised version of this report in the education and training of its administrative and clinical staff; and report back to HDC on steps taken and progress made towards ensuring appropriate oversight and management of internal referrals.

Complaint and investigation

4. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided to him by Southern District Health Board (now Te Whatu Ora Southern[1]). The following issue was identified for investigation:

- *Whether Te Whatu Ora Health New Zealand provided Mr A with an appropriate standard of care during November 2019 to March 2021 (inclusive).*

5. This report is the opinion of Deputy Commissioner Deborah James and is made in accordance with the power delegated to her by the Commissioner.

6. The parties directly involved in the investigation were:

Mr A	Consumer/complainant
Te Whatu Ora Southern	Provider

[1] The Pae Ora (Healthy Futures) Act 2022 took effect on 1 July 2022, establishing Te Whatu Ora Health New Zealand as the national organisation to lead and coordinate delivery of health services (replacing the previous district health board (DHB) system). Southern DHB has been replaced by Te Whatu Ora Southern.

7. Also mentioned in this report:

Dr B	General practitioner
Dr C	Consultant surgeon
Dr D	Surgical registrar
Dr E	Consultant surgeon

8. Further information was received from the man's medical centre.

9. Independent clinical advice was obtained from Dr Margaret Wilsher, Chief Medical Officer of Te Whatu Ora Te Toka Tumai Auckland (Appendix B).

Information gathered during investigation

Introduction

10. This report concerns the care provided to Mr A (aged in his twenties at the time of these events) at Southland Hospital regarding his treatment for repeated perianal abscesses between November 2019 and March 2021 and, in particular, the management of referrals during that time and the communication with Mr A.

11. A perianal abscess is an infection that appears as a painful red lump under the skin near the anus. The infection occurs when bacteria become trapped in the glands that line the anal canal. The bacteria and fluid (pus) form a red, painful lump. Surgical incision and drainage is the most common treatment for anal abscesses.

Referral system

12. At the time of these events, Southland Hospital used both electronic and paper referrals. External referrals such as those from general practitioners (GPs) came via the Electronic Request Management System (ERMS). Internal referrals were in paper form. All referrals were managed by a central referral centre.

13. Te Whatu Ora Southern told HDC that the referral centre managed the receipt and entering of the referral, and then managed the priority once the referral had been triaged by a clinician. After triage, the referral was recorded on the service's waiting list and the booking administrator booked an outpatient appointment within the appropriate timeframe.

14. Te Whatu Ora Southern said that general surgeons at Southland Hospital may have a surgical sub-specialty or special interest in breast, endocrine, upper gastrointestinal (upper GI), complex hernia, and colorectal surgery. All general surgeons and their subspecialties are part of the general surgery department, and not separate departments. All general surgeons manage acute admissions for perianal conditions, but for complex and/or recurrent presentations, the ongoing outpatient management of these patients is usually under the care of a general surgeon with a colorectal subspecialty.

First abscess 1 November 2019

15. Mr A initially received treatment for a perianal abscess on 1 November 2019 after he presented to the Southland Hospital Emergency Department (ED) on the advice of his GP, Dr B.

16. Mr A was admitted to the surgical ward under consultant surgeon Dr C and underwent an examination under anaesthetic (EUA) and the incision and drainage of the abscess. He was discharged the next day and referred to the district nursing service for wound cares. On 6 November 2019, it is documented that the postoperative wound had healed fully.

17. The discharge summary, which was copied to Dr B, includes advice to keep the surgical area dry, for Mr A to see his GP if he 'experience[d] on-going leakage', and to return to hospital if he experienced increased pain, swelling or fevers. It is noted that fistula formation should be considered if Mr A had on-going leakage.

18. An anal fistula is an infected tunnel between the skin and the anus. Most anal fistulas are the result of an infection in an anal gland that spreads to the skin. Symptoms include pain, swelling and discharge of blood or pus from the anus. Surgery is usually required to treat an anal fistula.

Second abscess April 2020

19. Mr A told HDC that he experienced a second perianal abscess in April 2020. On that occasion, based on advice from Dr B, he did not present to ED, due to the risk of contracting COVID-19,[2] and because his condition was not life threatening. Mr A said that the abscess burst on its own, and antibiotics prescribed by Dr B resolved the remainder of the abscess.

Third abscess 26 June 2020

20. On 26 June 2020, Mr A presented to the Southland Hospital ED with another perianal abscess, and his history of two previous abscesses within that year was noted. Following examination, he was admitted to the surgical ward.

21. Mr A was treated by the general surgery acute team under consultant surgeon Dr E, who was on acute cover during this period. However, Mr A was not seen by Dr E during this admission. Te Whatu Ora Southern told HDC that there was no requirement for this in light of the appropriate management plan and uncomplicated inpatient stay.

22. The discharge summary records that the abscess became self-draining on the ward. Mr A told HDC that on the second day, while he was waiting on the ward for treatment, the abscess burst. He stated:

> 'I rang for assistance and was told by the nurse they did not want to clean it until the surgeon could take a look. I was left sitting in the abscess drainage for 8 hours. This was an extremely uncomfortable and humiliating experience and to make matters worse

[2] At the time, New Zealand was in lockdown due to COVID-19.

there were 3 other patients in [the] room that could hear, see and knew the state that I was in.'

23. Te Whatu Ora Southern told HDC that the abscess burst at 2.30pm and Mr A was given analgesia. Mr A was waiting for the acute surgical team, but they were in theatre with another complex patient until 8.50pm. Te Whatu Ora Southern stated: '[Mr A] should have been cleaned and changed and for that omission the surgery service apologises.'

24. At around 9.30pm on 27 June 2020, a surgical registrar carried out an EUA, rigid sigmoidoscopy,[3] and incision and drainage of Mr A's perianal abscess.

25. Mr A was discharged on 28 June 2020. The discharge summary states that no fistula was found, grade 2 haemorrhoids were seen, and a rectal biopsy was taken. The discharge plan included management of the dressings by the district nurses, and attendance at Dr C's outpatient clinic in six weeks' time. Magnetic resonance imaging (MRI) was to be considered if the abscess recurred. The biopsy reported normal intestinal mucosa.[4]

26. Te Whatu Ora Southern said that the discharge summary was emailed to the surgical booking administration team, and on 29 June 2020 the administrator scheduled an appointment for 18 September 2020. Te Whatu Ora stated: 'This was the earliest possible appointment due to the backlog the department was experiencing following the COVID-19 lockdown earlier in 2020.'

Surgical follow-up

27. On 18 September 2020, Mr A attended a surgical follow-up appointment in the outpatient clinic with surgical registrar Dr D on behalf of Dr C. Dr D determined that the colorectal team should review Mr A after he had had an MRI scan to query any evidence of a fistula. Dr D wrote a referral letter to his colorectal colleagues. Although the clinic letter was dictated on 18 September 2020, it was not typed until 14 October 2020 and approved for sending on 18 October 2020, four weeks after the appointment.

28. An Impact on Life (IOL) questionnaire[5] was not sent to Mr A at the time of the colorectal referral decision on 18 September 2020. Te Whatu Ora Southern said that an IOL should have been sent for this initial referral, and the omission was a result of 'a breakdown in process'.

Explanation for delay in sending referral

29. Te Whatu Ora Southern said that on 18 September 2020, Dr D dictated two letters on the same dictation. At that time, Southland Hospital was experiencing high levels of dictations and had limited transcription capacity, so the dictations were outsourced to a third party for transcription. The third party was used to dealing with 'one dictation, one letter' and had to seek advice on splitting the dictation into two files, which took a few days to complete.

[3] A rigid sigmoidoscopy is a procedure to look at the rectum and lower colon using a special tube called a scope.
[4] The soft tissue that lines the body's digestive canals.
[5] A patient-rated questionnaire used to assess the overall impact of a health condition on daily living, as part of elective surgery prioritisation.

30. In addition, Dr D had not inserted Mr A's contact details into the original dictation and so it dropped to the bottom of the queue as there were no unique identifiers. This usually signalled an invalid dictation (ie, one that had been incorrectly submitted by the clinician for typing — usually a blank dictation).

31. Te Whatu Ora Southern said that it took until 1 October 2020 for the backlog to be identified, and another couple of days for Mr A's referral letter to be identified as a valid dictation that needed to be typed. It was then sent back to the Southland Hospital typists as the outsource company did not have access to the patient administration system to look up patient details. The catch-up of the backlog took until 18 October 2020, when the referral was finally sent. This included a letter to Dr B informing him of the colorectal referral.

32. Te Whatu Ora Southern said that it implemented a new dictation and transcription system as a result of COVID-19. Te Whatu Ora stated that the issues raised by the delay in sending Mr A's dictated referral letter have now been resolved and systems have been put in place to ensure that this does not happen again. Te Whatu Ora said that each clinic letter and referral is now typed in a timely manner.

Fourth abscess 5 October 2020

33. On 5 October 2020, while Dr D's referral was still being processed, Mr A contacted Dr B because he had a fourth abscess. Mr A told HDC that he had run out of sick days due to the prior abscesses and could not afford to be off work for the two-week recovery time after surgery. As he knew that the MRI referral had been done, he decided not to present to ED but instead he contacted Dr B and was prescribed antibiotics. Mr A said: 'It took a month course of antibiotics and pain medication to get through this episode.'

34. Dr B sent a referral via ERMS to the general surgery department at Southland Hospital to update the department about Mr A's condition. This was treated as a new referral and Mr A was sent an IOL questionnaire, which he duly completed and returned. Dr B was unaware that the colorectal referral was being progressed, as he was not sent the letter informing him of it until 18 October, due to delays with the transcribing of Dr D's referral dictation.

35. Te Whatu Ora Southern told HDC that Dr B's referral appeared to the booking administrator to be a recurrence of the presenting problem, and so the administrator booked Mr A back into a general surgery clinic.

36. On 30 October, the referral centre received Dr D's referral to the colorectal team (which he dictated on 18 September). This was entered into ERMS on 2 November 2020. On 1 December it was prioritised as urgent[6] but also referred back to general surgery instead of colorectal surgery. An appointment was made for 21 December 2020.

37. The referral was assigned to Dr E. Dr E stated:

> 'The correspondence from GP to the Surgical Department "For your information" was assigned to me without appropriate review of this gentleman's HCS [clinical intranet]

[6] Which has a target of 'see within two weeks'.

> background notes as it would have been noted that ongoing management was not under the care of [Dr E], but rather under the care of [Dr C] (Surgical Consultant). As I recall when I saw the correspondence sometime Nov/Dec 2020, I confirmed that appropriate follow-up [21 December 2020] had already been scheduled/completed.'

38. Te Whatu Ora Southern told HDC that this referral back to the general surgery clinic was incorrect. Te Whatu Ora stated:

> 'A more thorough review of this patient's records would have noted that a plan had already been instigated for [the] patient to be seen by a colorectal interest surgeon. Such a thorough review of ERMS is now taking place and putting better systems in place to ensure the patient is booked into the outpatient clinic with the most appropriate surgeon for their specific condition.'

MRI scan

39. On 12 October 2020, Mr A had an MRI scan, which demonstrated a posterior intersphincteric sinus tract (a fistula that crossed the internal sphincter with a tract to the outside of the anus).

40. Mr A said that he was told that he would get a call with the MRI results within a week, but he did not hear anything further.

Outpatient appointment on 21 December 2020

41. On 21 December 2020, Mr A attended a general surgery outpatient clinic with Dr D. Mr A said that Dr D was surprised to see him and told him that he was in the wrong clinic. Dr D said that Mr A should have been referred on to the colorectal unit but, instead, had been sent back to the surgical team. Mr A stated that Dr D told him that there was not much he could do for him and that he would refer him to the colorectal team for a second time.

42. Dr D re-referred Mr A internally to the colorectal service. This letter was typed and sent on 6 January 2021 and specifically clarified to the colorectal nurse that it was a colorectal referral, which had originally been made in September. Te Whatu Ora Southern said that there is no evidence of action having been taken on this referral. It should have been loaded as 'current to service' but this did not occur.

Fifth abscess January to March 2021

43. Mr A said that he developed another abscess and started antibiotics in mid-January 2021. He stated that the antibiotics seemed to be becoming less effective, and the first two courses did not assist with reducing the abscess, which grew steadily. He was then put on a more aggressive antibiotic. He said that a side effect of that antibiotic is sensitivity to the sun, which caused issues for him.

44. On 10 February 2021, Dr B sent a referral to the gastroenterology department, querying whether Dr D's 18 September referral had been lost. Because there was no evidence of a previous referral to gastroenterology that could have been 'lost', gastroenterology

forwarded the referral to general surgery on 11 February 2021. This appears to have then been treated as a fresh referral, and a second IOL questionnaire process was triggered.

45. Te Whatu Ora Southern told HDC that an IOL was not required for patients active in its service, and an IOL should not be sent unless requested by the triaging clinician, which was not the case here. Te Whatu Ora accepted that this IOL was requested in error.

46. On 16 February 2021, Dr B's 5 October referral was marked as closed by Dr E as Mr A had already had an MRI and had attended the outpatient clinic appointment on 21 December 2020. Neither Mr A nor Dr B was informed of this, although the GP would have been able to view the comment in HealthConnect South.

47. Te Whatu Ora Southern said that the reasons for the delay in the closure of the October referral were that Dr E worked part time and had periods of leave through December/January, the ERMS system was a new platform for triaging, and dedicated triaging time for triage clinicians was not scheduled. Dr D's internal 6 January 2021 referral was still not present on the system.

Appointment 22 March 2021

48. Because Mr A had still not received any follow-up since the 21 December clinic, on 3 March 2021 he called Southland Hospital, and on 4 March he spoke to a colorectal clinical nurse specialist. Mr A told HDC that she had no explanation as to why the referrals had not been actioned, and she was not sure what had happened. Regarding the referral from the GP on 10 February 2021, she said that they were now waiting for Mr A's IOL questionnaire to be returned. Mr A had not received the IOL and there is no record that it was sent.

49. Mr A said that the colorectal clinical nurse specialist told him that she could book a general surgery review for him. Subsequently, Mr A was seen on 22 March 2021 by a general surgeon with a colorectal subspecialty.

50. A summary of Mr A's overall referral process is included at Appendix A.

Complaint

51. Because of the delays in the referral and treatment process, Mr A emailed a written complaint to HDC and Te Whatu Ora Southern, which stated:

> 'I am disappointed that I have been unable to receive timely consultations or referrals to correct specialist in order to get treatment. I would appreciate it if the organisation would look into why the referrals are not going through to the correct area and why [the delays] have occurred. I feel that I've been left in the dark to suffer with my medical condition. I really would like to just have the issue resolved and hope that other people with similar conditions don't have to suffer waiting for appropriate treatment as long as I have.'

52. Mr A noted that during the time he received care, a person he knew worked at Te Whatu Ora Southern. Mr A stated:

> 'If it wasn't for [that person's] help I would likely not [have] received the treatment I needed, as I wouldn't know it had been too long and would have trusted I hadn't been forgotten. I also wouldn't have known who to contact as my GP had already followed it up with no success.
>
> …
>
> My concern is people who have less knowledge of the process would have their condition deteriorate as mine did, potentially leading to a negative outcome. I was lucky [I knew someone who] could help me, but most people would have not [have] known what to do and might still be waiting.'

53. Mr A had surgery to repair the fistula in late April 2021 at a private hospital, upon referral by Te Whatu Ora Southern. He told HDC that since having the surgery he has been able to go back to work and has been doing well.

Further information Te Whatu Ora Southern

54. Te Whatu Ora Southern apologised for the multiple delays and communication failures throughout Mr A's patient journey.

55. Te Whatu Ora told HDC:

> 'We are very sorry for the suffering and frustration that [Mr A] experienced while seeking treatment for his perianal abscesses. The Service Manager, Surgical Services at Southland Hospital, has phoned [Mr A] to apologise for his delays to treatment. While we are pleased to report [Mr A] has now had his surgery and is on the road to recovery, we acknowledge his patient journey could have been much smoother.'

56. Te Whatu Ora said that at the time of these events, referrals from the ERMS system were managed by one person, who covered the entire hospital. There was no reporting on triaging and processing, which would have picked up Mr A's referral awaiting triage. Te Whatu Ora stated that it has since changed its process to ensure that referrals are not left at any stage of the referral pathway unless there is a good reason (either clinical or awaiting further information), which is noted and approved by the clinical lead. Delayed referrals are measured on a weekly basis, while all other referrals are monitored in real time.

Responses to provisional opinion

57. Mr A was given a copy of the 'Information gathered' section of the provisional report for the opportunity to comment. In response he stated:

> 'In summary I must say my trust and confidence in the health system has been broken. Which Is not ideal given [my family] will likely have to engage with the system. And to be honest I have doubts whether it will get better …'

58. Te Whatu Ora Southern was given the opportunity to respond to the full provisional report. Te Whatu Ora's comments focused on changes that have been made since the events, and these have been incorporated below where appropriate.

Opinion: Te Whatu Ora Southern — breach

Introduction

Mr A suffered repeated painful anal abscesses that impacted on his employment and day-to-day life. Multiple referrals were made from September 2020 to February 2021, all relating to the same health issue. He quite reasonably feels he was let down by Southland Hospital's referral systems, delays, and poor communication. I take this opportunity to acknowledge his difficult journey and the distress and frustration he experienced.

59. Te Whatu Ora Southern has acknowledged and apologised for the delays and difficulties in Mr A's patient journey (a summary of which is included at Appendix A), and for the failures in communication.

Expectations for referrals

60. Te Whatu Ora Southern's target timeframes for referrals are: 'Urgent — two weeks, Semi-urgent — six weeks, Routine — 12 weeks.'

61. At the time, the New Zealand Standard Health and Disability Services (Core) Standards (NZS 8134.1:2008) outlined the responsibility of healthcare providers to ensure that 'consumers receive timely services which are planned, coordinated and delivered in an appropriate manner', including 'continuum of service delivery'.[7]

Management of Mr A's referrals

62. Initially, Mr A was referred from general surgery to a colorectal subspecialist on 18 September 2020, with the referral supported by the 12 October 2020 MRI evidence of a fistula. On 1 December 2020 the referral was prioritised as urgent (two weeks) by the referral centre. An appointment on 21 December 2020 was made incorrectly with general surgery, and the subsequent internal referral from that appointment, typed on 6 January 2021, appears not to have been received by the referral centre. Further opportunities for appropriate and timely management of Mr A's care were missed after his GP made further referrals in October 2020 and February 2021 for Mr A to be seen, which encountered similar system issues and delays.

63. After receiving no communication about his appointment, and with his GP's efforts to advocate on his behalf having been unsuccessful, Mr A personally followed up with the colorectal nurse on 4 March 2021. An appointment was then made with the correct specialist for 22 March 2021, six months after the original referral appointment on 18 September 2020, which had been prioritised as urgent (two weeks) on 1 December 2020. The pathway for each referral was either delayed at typing, incorrectly directed to the wrong department, closed prematurely, or never received by the referral centre.

[7] https://www.standards.govt.nz/shop/nzs-8134-12008

Referral system

64. At the time of these events, Southland Hospital used a paper referral management system for internal referrals. A backlog in the system had resulted in delays between letters being dictated, sent, and received by the intended recipients.

65. I sought advice from Dr Margaret Wilsher, Chief Medical Officer of Te Whatu Ora Te Toka Tumai Auckland, who has experience in medical administration leadership and systems review. She advised that there should have been a timely and safe referrals management system, supported by agreed timeframes and the appropriate resources.

66. Clearly, the systems at Southland Hospital at the time were inadequate, as discussed further below. While individuals may have contributed to some of the delays, in my view, Te Whatu Ora Southern holds overall responsibility for having a referral system that enables referrals, and potential errors, to be tracked and monitored adequately.

Referral delays

*18 September 2020 r*eferral

67. Dr D saw Mr A in the general surgery outpatient clinic on 18 September 2020. Dr D decided that Mr A should have an MRI scan, following which, the colorectal team should review Mr A. Dr D dictated a referral letter to his colorectal colleagues, but he provided insufficient details about Mr A, so the transcription was delayed. Te Whatu Ora Southern said that a high level of dictations and limited transcription capacity meant that dictation had been outsourced, but this transcription had to be returned to the internal system because of the need to obtain the missing details from the patient information system.

68. The letter was typed on 14 October 2020 and approved for sending on 18 October, four weeks after the appointment. The letter was received by the referral centre two weeks later, on 30 October 2020. Four weeks later, on 1 December 2020, a referral prioritisation form was completed incorrectly for the general surgical service rather than the colorectal surgical service.

69. Dr Wilsher advised that ordinarily, letters should be dictated on the day the patient is seen in clinic and should be typed, proofed, and approved for sending within two weeks. She stated that the further two-week delay was a mild departure from the standard of care, noting that the initial referral was not urgent. Te Whatu Ora Southern agreed that this was a mild departure from accepted standards.

70. There was a further month's delay before the prioritisation. Dr Wilsher advised:

> 'Taken individually all of these steps would be generally acceptable compared with current standards for non-urgent referrals but the cumulative impact is a 10-week delay from referral to prioritisation which would not comply with standards now possible with internal electronic referral platforms.'

71. Dr Wilsher said that the delay constituted a moderate departure from the accepted standard of care, and Te Whatu Ora Southern accepted this.

72. In addition, an error was made in that the prioritisation form was for the general surgical service rather than the colorectal service. I am critical that the system did not detect and rectify this error. Dr Wilsher commented that systems should be designed to ensure that a referral is routed to the appropriate clinician for grading, and that the clinician has the appropriate time, tools, and facility in which to undertake the task. I accept this advice.

5 October 2020 referral

73. On 5 October 2020, as Mr A had a further abscess, Dr B updated the surgical outpatient team by way of an electronic referral. It is unclear whether this was intended as a new referral, but Southland Hospital treated it as such and sent an IOL questionnaire to Mr A, which subsequently he returned.

74. On 26 October 2020, the referral was assigned to Dr E but there was then a delay in reviewing the referral on the ERMS system until 16 February 2021, when it was then closed because the 21 December 2020 appointment had taken place. Dr Wilsher advised:

> 'Even taking into account that the GP sent the referral for information only, the delay of over three months highlights a major departure from the standard of care in prioritising a GP referral.'

75. I agree, but I note that Dr E was influenced by the completion of the 21 December appointment, and at that stage the fresh referral to colorectal surgery was not yet in the referral system. Therefore, this is a systems error exacerbated by the initial misdirection of the original internal referral back to general surgery, and the failure of the 21 December internal referral to be received by the referral centre.

76. Te Whatu Ora Southern accepted Dr Wilsher's advice and said that as a result of these events it made a number of changes (see below).

1 February 2021 referral

77. Dr B saw Mr A on 1 February 2021 and referred him to gastroenterology on 10 February 2021, noting that he appeared to have been lost to follow-up. The referral was forwarded to the general surgery department on 11 February as there had not been a previous referral to gastroenterology. Another IOL questionnaire was sent incorrectly, which appeared to halt the referral process while Mr A's response to the IOL was awaited.

78. Mr A said that he did not receive an IOL questionnaire at that time, and Te Whatu Ora Southern has no evidence that an IOL was sent to him. In any event, an IOL was not required for patients active in Southland Hospital's service unless requested by the triaging clinician, which was not the case here.

79. The referral was acknowledged on 17 March 2021, and comment made that Mr A already had a scheduled appointment with a colorectal surgeon on 22 March 2021. This appears to have been as a result of Mr A's direct contact with the colorectal nurse on 4 March 2021.

80. Dr Wilsher stated that it is not clear why there was a five-week prioritisation delay, which she considers was a mild departure from the accepted standard of care. She said that

ordinarily a non-urgent referral should be prioritised within four weeks. I have considered this advice, and my view is that the mild departure is significant in the broader context of multiple delayed, misdirected, and lost referrals.

Conclusions

81. Overall, Mr A experienced multiple unacceptable delays in the management of his referrals and confusion about the appropriate service to provide his care. This resulted in Mr A not receiving timely consultations and treatment, despite having been prioritised as urgent on 1 December 2020. Accordingly, Mr A was not provided services with reasonable care and skill, and therefore I find that Te Whatu Ora Southern breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.[8]

Communication and respect — adverse comment

82. Mr A was suffering from a painful condition that affected his quality of life and employment, including running out of sick leave and resultant financial implications. I am critical of the lack of communication, consideration, and respect he received.

83. For example, on 27 June 2020 while Mr A was waiting for surgery, his abscess burst. The nurse told him that they did not want to clean it until the surgeon had reviewed him. Consequently, he was left sitting in the abscess drainage for eight hours. He said: 'This was an extremely uncomfortable and humiliating experience and to make matters worse there were 3 other patients in [the] room that could hear, see and knew the state that I was in.'

84. Te Whatu Ora Southern has accepted that Mr A should have been cleaned and changed, and it apologised for this omission.

85. Mr A then found the referral and prioritisation system confusing and unhelpful, as he was moved between the general surgery and colorectal services. His GP attempted to advocate on his behalf without success, so Mr A contacted the colorectal nurse for assistance. There appears to be no record of his contacts with Southland Hospital while attempting to clarify the situation. I am critical that there was not a process to record queries and ensure that an appropriate person responded and supported Mr A.

86. This was poor care that contributed further to Mr A's ongoing discomfort. I am critical of the lack of courtesy shown to enable timely information and access to treatment.

Changes made

87. Te Whatu Ora Southern conducted a review of its colorectal services to improve the internal referral process. As a result, Te Whatu Ora made the following changes:

[8] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

- It conducts referral triaging clinics each week for general surgery with the consultant, nurse, registrar (dependent on other commitments), and administration staff present.
- It has arranged further training where required on the ERMS prioritisation process.
- It has developed a quick guide for consistent triaging.
- It has developed a subspeciality allocation list for referrals (ie, identifying which consultant clinic each referral type can be seen in).
- It has developed an internal referral request form to remove the risk associated with paper referrals.
- Reporting and active management of outstanding referrals awaiting triage now occurs and is reviewed and managed daily at Southland Hospital.

88. Te Whatu Ora Southern said that the referral guidelines document will continue to be refined, and it is progressing the use of the internal ERMS system to ensure proper oversight of internal referrals.

89. Southland Hospital has implemented an electronic internal request form for general surgery to reduce the number of paper referrals that are received in the service. It is recognised that paper referrals always represent higher risk than those received electronically, and it is continuing to develop processes that digitalise paper referrals to reduce the inherent risk this brings.

90. A new dictation and transcription system was implemented on 1 January 2022, and 96.9% of clinic letters and referrals have been turned around within the five-day timeframe required.

91. Clinicians' roles and accountabilities are covered in orientation, and the triaging guide continues to be refined further.

92. A new patient management and booking system, 'SIPICS[9]', is to be implemented in November 2023. In response to the provisional report, Te Whatu Ora stated that this system will work as follows:

> 'Comments are able to be added to a specific booking, however these are for the benefit of the booking staff and not meant as a means of clinical communication. The process for verbal communication is that the caller is firstly put through to the most appropriate secretary. If they are able to deal with the query (non-clinical) they will do so. If the query is clinical in nature, the team have been instructed:
>
> - For services with specialist nurses or navigators, to transfer the call to them as appropriate;
> - For all other services, advise the patient to raise the issue with the GP who can in turn either update the referral information or have the appropriate clinical

[9] South Island Patient Information Care System.

conversation with the relevant specialty team (if urgent). This provides a much more reliable chain of communication which, if the referral system is used, can be reviewed and audited as necessary.'

Recommendations

93. I recommend that Te Whatu Ora Southern:

a) Within three weeks of the date of this opinion, provide a written apology to Mr A for the failures of care identified in this report. The apology is to be sent to HDC for forwarding.

b) Consider utilising an anonymised version of this report in the education and training of administrative and clinical staff, and, within three months of the date of this opinion, report back to HDC on any such education provided.

c) Evaluate the effectiveness of SIPICS (once implemented) through an audit or other appropriate mechanism, and, within six months of the date of this opinion, report to HDC on the outcome of the evaluation. The evaluation should in part have a focus on how the issues identified in this report have been remedied by the new system.

d) Within six months of the date of this opinion, report on progress with the implementation of the use of the ERMS system for internal referrals.

Follow-up actions

94. A copy of this report with details identifying the parties removed, except Southland Hospital, Te Whatu Ora Southern, and the advisor on this case, will be sent to Te Tāhū Hauora|Health Quality & Safety Commission, the Royal Australasian College of Surgeons, and the Royal New Zealand College of General Practitioners, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Timeline of referral process

Timeline of referral

- 18 September 2020 — Dr D referred Mr A to colorectal and MRI.
- 5 October 2020 — Dr B referred Mr A to general surgery via ERMS with update on Mr A's condition.
- 12 October 2020 — MRI scan reported a fistula.
- 14 October 2020 — Dr D's referral letter typed.
- 18 October 2020 — Dr D's letter checked in dictation system, printed and sent to referral centre for uploading to patient management system.
- IOL questionnaire sent to Mr A in response to 5 October 2020 referral.
- 22 October 2020 — Mr A returned IOL.
- 26 October 2020 — Dr B's referral assigned to Dr E and identified as scheduled in general surgery.
- 30 October 2020 — Dr D's referral letter received in referral centre.
- 2 November 2020 — Referral entered into patient management system and referred to colorectal service for triaging.
- 1 December 2020 — Referral triaged as urgent and returned to referral centre for uploading to general surgery waiting list.
- 3 December 2020 — Referral entered on waiting list in patient management system.
- 21 December 2020 — Incorrect general surgery outpatient appointment. Dr D re-referred Mr A to colorectal service.
- 6 January 2021 — Dr D's referral letter typed, again clarifying that referral is to colorectal team.
- 10 February 2021 — Dr B sent update to gastroenterology team, querying whether September referral had been lost.
- 11 February 2021 — Dr B's referral forwarded to general surgery department.
- 16 February 2021 — Dr B's 5 October referral marked as closed.
- 3 March 2021 — Mr A telephoned Te Whatu Ora Southern to follow up referral.
- 4 March 2021 — Mr A spoke to colorectal nurse and appointment scheduled for 22 March 2021.
- 22 March 2021 — Outpatient appointment in general surgeon's colorectal clinic.

Appendix B: Independent clinical advice to Commissioner

The following clinical advice was obtained from Dr Margaret Wilsher:

'**Report for Commissioner — 21HDC00522.**

1. I have been asked to provide advice to the Commissioner on case number 21HDC00522 and I have read and followed the Commissioner's Guidelines for Independent Advisors.

2. My qualifications are as follows: MB ChB, University of Otago; MD, University of Otago; Fellow, Royal Australasian College of Physicians; Distinguished Fellow, Royal Australasian College of Medical Administrators; Fellow Thoracic Society of Australia and New Zealand. I am currently the Chief Medical Officer for Auckland District Health Board and Honorary Professor of Medicine, Faculty of Medical and Health Sciences, University of Auckland. I am accountable for the clinical practice and professional standards of over 1500 doctors employed by ADHB and have been involved in medical leadership and health management for over 15 years. I am a practising physician in public and private sectors, a clinical researcher and teacher. I also hold chartered membership of the New Zealand Institute of Directors and sit on a number of external health related governance and advisory committees and boards.

3. My referral instructions from the Commissioner are to provide an opinion on the care provided by Southern District Health Board (SDHB) to [Mr A] between November 2019 and March 2021 (inclusive).

4. I have been provided with the following information: Letter of complaint dated 8 March 2021. SDHB's responses dated 6 May 2021 and 10 November 2021. Clinical records from SDHB covering the period 1 November 2019 to 24 April 2021. Clinical records from [Mr A's GP] covering the period 1 November 2019 to 10 February 2021.

5. **Background**

[Mr A] complains about delayed referrals and treatment for perianal abscesses. [Mr A] (aged [in his twenties] at the time) first underwent a surgical incision and drainage at Southland Hospital on 1 November 2019, after which he received no follow-up. The discharge summary stated "if you have on-going leakage, please see your GP." [Mr A] developed a second abscess and on 6 April 2020 was prescribed antibiotics by his GP, [Dr B]. He did not present to the Southland Hospital ED on this occasion because of the level 4 Covid-19 lockdown. The abscess burst on its own. On 26 June 2020, [Mr A] presented to the ED with a third abscess. While waiting for his surgery, the abscess burst and [Mr A] sat waiting eight hours in the drainage. [Mr A] says that "he rang for assistance and was told by the nurse they did not want to clean it up until the surgeon could take a look … this was an extremely uncomfortable and humiliating experience." SDHB have apologised for this omission and explained that "[Mr A] should have been cleaned and changed." [Mr A] underwent a rigid sigmoidoscopy and surgical incision and drainage. The discharge summary stated that [Mr A] was to have a six week follow-

up appointment with [Dr C] (Consultant, General Surgery Department) for "consideration of MRI if having recurrence." On 18 September 2020, [Mr A] attended a surgical follow-up appointment with [Dr C]. [Dr C] requested an MRI and referred [Mr A] to be seen by the colorectal team. On 5 October 2020, [Mr A] presented to his GP with a fourth abscess. The GP referred [Mr A] to be seen by the General Surgery Department at SDHB. On 21 December 2020, [Mr A] attended an outpatient surgical appointment and was seen by [Dr D], Surgical Registrar. [Mr A] was told that he was in the wrong clinic and should have been referred to the colorectal team. [Dr D] made another referral for [Mr A] to be seen by the colorectal team. On 10 February 2021, [Mr A] contacted his GP to go back on antibiotics due to a fifth abscess. The GP made a referral for [Mr A] to be seen by the Gastroenterology Department. On 3 March 2021, [Mr A] followed up with SDHB regarding his referral to the colorectal team. [Mr A] says that he was told that they had not received the first two referrals and that the third had been looked at in mid-February, but not actioned. On 4 March 2021, [the colorectal nurse] rang [Mr A] and arranged a colorectal consultation for 22 March 2021. [Mr A] was advised that they were waiting for his quality of life survey. [Mr A] says the last quality of life survey he received was on 20 December 2020. On 21 April 2021, [Mr A] underwent a surgery for the fistula.

OPINION

6. **The manner in which SDHB managed [Mr A]'s referrals: Referral made on 18 September 2020 by [Dr C] to the colorectal team to review [Mr A] and his MRI results. Please also include comment on the booking error and the dictation and triaging delays.**

[Dr D], surgical registrar saw [Mr A] in the outpatient clinic on 18 September 2020 on behalf of the clinical lead [Dr C]. He determined that the colorectal team should review the patient with the results of an MRI scan and wrote a referral letter to his colorectal colleagues. It is not clear when the clinic letter was dictated but it appears not to have been typed until 14 October 2020 according to the SDHB. It appears that it was approved for sending on 18 October. SDHB states that high level of dictations and limited transcription capacity meant that outsourcing was required. Because insufficient details were provided by [Dr D], the letter dropped to the bottom of a queue. Subsequently, backlog management, including insourcing, was required by the DHB in order to ensure all letters were completed and sent. [Dr D] states that he referred [Mr A] for an MRI scan pelvis. The referral was received by the referral centre on 30 October 2020. Subsequently a general surgery referral prioritisation form was completed for the General Surgical rather than Colorectal Surgical service. The prioritisation date was 1st December 2020. Ordinarily letters should be dictated on the day the patient is seen in clinic and typed, proofed and approved for sending within two weeks. Leave and sickness can confound adherence to this standard. I would consider a further two week delay a mild departure from the standard of care noting that the referral was not urgent. It appears that SDHB uses a paper referral management system for internal referrals which accounts for a two week delay between the letter being sent and then receipt by the intended recipient. Subsequently a further month delay ensued before actual prioritisation. Taken individually all of these steps would be generally

acceptable compared with current standards for non-urgent referrals but the cumulative impact is a 10 week delay from referral to prioritisation which would not comply with standards now possible with internal electronic referral platforms. It is hard to state that this is a major departure from the standard of care when benchmark standards are historically determined by the resources individual DHBs have had. Given that electronic systems now exist and have been successfully implemented in many DHBs, then I would consider that the internal referral management standard should be the same as the external and that internal referrals should be prioritised within four weeks, and urgent referrals within 2 weeks. This delay constitutes a moderate departure from the standard of care.

I am unable to comment on the booking error. Undoubtedly human factors were at play. With hindsight bias one can, of course, state that this action does not meet the standard of care but humans are fallible and systems should be designed to ensure that a referral is routed to the appropriate clinician for grading and that the clinician has appropriate time, tools and facility in which to undertake the task. SDHB states, in its letter 6 May 2021 that the referral from [Dr C] was not actioned. That is not correct as the referral was actioned but the wrong action was taken.

Referral made on 5 October 2020 by the GP to the General Surgery Department. Please also include comment on the delay in the referral being actioned, from when it was assigned on 26 October 2020 to when it was reviewed on 16 February 2021.

On 5 October 2020, [Dr B] undertook phone consultation with [Mr A] who complained that he had a relapse of a painful lump in the perineum. The GP made a decision to update the surgical outpatient team which he did using a "for your information" referral on the same day. It does not appear that this was intended as a referral per se. However, SDHB indicates that the referral was treated as such and an Impact on Life questionnaire was sent to the patient and subsequently received back. On 26 October, the referral was assigned to [Dr E] but there was a delay in reviewing the referral until 16 February 2021. Even taking into account that the GP sent the referral for information only, the delay of over three months highlights a major departure from the standard of care in prioritising a GP referral.

Referral made on 21 December 2020 by [Dr D] on 21 December 2020 to the colorectal team. Please also comment on SDHB's response that "there is no evidence of action taken on this referral. It should have been loaded as current to service but this did not occur".

[Dr D] saw [Mr A] on 21 December and again determined that he needed to be referred to the colorectal team. He dictated a letter to the colorectal CNS on 21 December 2020, and that letter was sent 6 January 2021. This letter appears to have been directly made to an individual clinician so it is not clear whether it bypassed the referrals management administration team. The time of year is noted. It is not clear if SDHB made enquiries of the CNS to ascertain whether she had received the letter directly. However, a booking was subsequently made with [a colorectal surgeon], on 22 March 2021.

Referral made on 10 February 2021 by the GP to the Gastroenterology Department.

[Dr B] GP saw [Mr A] on 1st February 2021 and referred him to SDHB gastroenterology on 10 February noting that he appeared to have been lost to follow-up. The referral was acknowledged 17 March and comment made that [Mr A] already had a scheduled appointment with a colorectal surgeon on 22 March. It is not clear why there is a 5 week prioritisation delay which is mild departure from standard of care. Ordinarily a non-urgent referral should be prioritised within 4 weeks.

7. **The timeliness of SDHB scheduling a follow-up appointment for [Mr A] following discharge on 28 June 2020.**

The discharge plan for [Mr A] on 28 June 2020 was for 6 week follow-up with [Dr C] and "MRI if having a recurrence". A district nursing referral was made and a prescription provided. SDHB states that the discharge summary was emailed to the surgical booking administration support on 29 June and an appointment was scheduled for the 18 September. This was the earliest that the department could provide in the circumstance of the Covid lock down backlog of appointments. In normal circumstances the standard of care would be 6 week followup following surgical intervention. The 2020 Covid lockdown and disruption to planned care resulted in nationwide delays impacting ambulatory care. I do not consider in this context that a 4 week delay to a post op followup is material and therefore not a departure from the standard of care at the time.

8. **The systems that would be reasonably expected for a DHB to have in place to identify delays in arranging, processing, triaging and actioning referrals and correcting administrative human errors.**

A DHB should have an electronic external and internal referrals management system which allows for timely and safe referrals management. This should be supported by agreed triage timeframes, dictation and document sign off timeframes and wait times for clinic appointment based on predetermined prioritisation criteria. All clinical and administrative staff involved in referrals management should be aware of those published standards. All staff need appropriate resource to ensure that they can complete their assigned tasks effectively in a timely manner. Attention to workload, work environment, processes and systems can help ensure that work done is as imagined. There must be checks and balances in case of human oversight. When electronic systems are yet to be fully implemented then process maps and lean methods can help with paper system efficiency. Qualified improvement specialists can add value to such work.

9. **The adequacy of the various remedial steps proposed and being implemented by SDHB to address the issues identified in this case relating to the referral system.**

SDHB states that it has changed its Electronic Referrals Management System process to ensure referrals are not left at any stage of the referrals pathway unless for good reason. It is not clear how it has made this change but it does report that it measures on a weekly basis whilst all other referrals are monitored in real time. No comment is

made about improvements to aspects of the pathway that appear to remain paper based. SDHB comments that a new dictation and transcription system is in place and that clinic letters and referrals are typed in a timely manner. It makes no comment on time to actual dictation or time to sign off after typing so the standard remains unclear. SDHB states that it has a 30+ page referrals manual which covers all policies relating to referrals from receipt to completion. A summary is provided. Staff tasked with ensuring that referrals management is safe and timely need to know what their role is, what their accountabilities are and what the standard is. Information needs to be relevant and accessible. It is unlikely that clinicians will refer to this 30 page document. Information regarding roles and accountabilities needs to be provided at orientation, be visible and accessible, and simple. SDHB has now implemented weekly referral triaging clinics in general surgery. This is an appropriate improvement. There is now a quick guide for consistent triaging which should be made available to all new staff. It is developing an internal referral request form and is keen to progress with electronic internal referral management. It is only with the latter system improvement that the DHB will have confidence in referrals management. A formal internal referral request form is only an improvement over a paper referral letter if the processes regarding internal referral management are improved at the same time.

10. **[Mr A's] concern that he did not hear back about his MRI results after being told he would receive them within one week of the scan.**

It is not always possible to provide the result of an investigation within a week. Scans need to be reported and the typed report reviewed and signed off. Unless there is an agreed process whereby results are copied directly to patients then further delay ensues as the referrer receives and takes action on the result. The standard is not agreed but this reviewer considers within two weeks would be ideal and up to 4 weeks for a non-urgent investigation where the result is provided to the patient by the referrer. However, my peers increasingly support direct copy of the result to the patient as well as referrer and GP (if not the referrer).

11. **Any other relevant matters in this case that you consider warrant comment, including any proposed recommendations that SDHB should adopt.**

It is helpful when patients ring with queries to document the query and the response in the clinical record or referrals management system. It is unclear if conversations with [Mr A] in response to his phone queries were documented. It is suggested that the DHB, if it does not already have one, develop a system of capturing patient queries and ensuring these are routed to a person who can address them. Health systems can be impenetrable for patients. [Mr A] describes calling gastroenterology and not getting a response to his call or to a left message. It is clear that his quality of life was impacted by his recurrent perianal abscess and that his employment was impacted. What matters to patients is not always fully understood by those who work in the health system — no reference is made in the clinic letters to the impact on his quality of life. [Mr A] experienced whakamā when he was left in his own perianal abscess fluid in bed in hospital and his written complaint hints at despondency as he was impacted by repeated delays to definitive intervention. This complaint is of learning value as it

reinforces how our systems do not always put the patient at the centre of care. Patient related outcome measures are useful tools and the quality of life questionnaire that he filled out is such an example. It is not clear how this was used other than for prioritisation purposes. It is suggested that SDHB use patient stories of their experience to illustrate the importance of meeting agreed standards of care. I acknowledge the extraordinary circumstance of the Covid pandemic and the consequent impact on DHB delivery of planned care, and the impact on workforce. I acknowledge [Mr A] and his story.

Yours sincerely

Margaret Wilsher MD, FRACP, FRACMA Chief Medical Officer'